Child Protection Accountability Commission
Training Committee
De-Escalation of Life Support Workgroup
May 1, 2017
A.I. duPont Hospital for Children

Meeting Minutes

In Attendance:

Carole Davis, Esq.	Department of Justice
Dr. Allan De Jong	A.I. duPont Hospital for Children
Danielle Dell	Family Court
Dr. Stephanie Deutsch	A.I. duPont Hospital for Children
Dr. Meg Frizzola	A.I. duPont Hospital for Children
Susan Gordon, Esq.	Christiana Care
Mark Hudson, Esq., Co-Chair	Office of the Child Advocate
Honorable Peter B. Jones	Family Court
Dr. Elissa Miller	A.I. duPont Hospital for Children
Phyllis Rosenbaum, Esq.	A.I. duPont Hospital for Children
Molly Shaw, Esq., Co-Chair	Office of the Child Advocate
Susan Taylor-Walls	Division of Family Services
Janice Tigani, Esq.	Department of Justice

I. Welcome and Introductions

The Co-Chairs opened the meeting and attendees introduced themselves.

II. Approval of Minutes – 3/1/17 Meeting

The draft minutes were approved with one noted revision.

III. Discussion of Multidisciplinary Response Area 1: Initial Communication/Investigation in Early Stages of Case

Discussion began with an understanding that the group would attempt to focus on fact patterns where a child presents at a hospital with serious, potentially life-threatening injuries, and it is apparent that the injuries are suspicious for non-accidental abuse by the parents. The group acknowledged that there are many other scenarios the hospital encounters that are likely relevant to its discussion, but that it will attempt to address those after creating a protocol that will serve as a framework for other types of cases.

a. Hotline/Law Enforcement Referral

The group identified key information DFS felt was important for hospital staff to communicate in a hotline referral, including:

- Suspicion of non-accidental trauma
- Severity of the injury and the need for immediate medical decisions
- Complicating factors, such as parental substance abuse or domestic violence
- Parental cooperation and behavior, such as demeanor and interaction with the child
- Whether police have been contacted

Although the hotline does not currently have the ability to discriminate among callers, DFS is looking into the possibility of adding a separate line for callers from the medical field, law enforcement, etc. However, hospital staff can complete a referral online to avoid long hold times on the hotline. Ms. Taylor-Walls reported online referrals go directly to a worker on the hotline shift. Any online referral must be addressed during the 8-hour shift in which it is received, and P1 referrals will be responded to immediately.

In addition to contacting the DFS hotline, hospital staff will usually contact the police in cases of suspected abuse.

Hospital staff defined parental cooperation as a willingness to sit down with the doctors and be educated on all medical options; in other words, active participation in an informed consent conversation. In addition, the parent should make decisions that are in the child's best interest and that are reasonable within the family context of values and beliefs.

b. DFS/DOJ Response

Susan Taylor-Walls explained that there are 3 priority response levels to hotline referrals: P1 requires DFS response within 24 hours, P2 requires response within 72 hours, and P3 requires response within 10 days. She noted that in most cases of visible injury, a P1 response is warranted and will occur as soon as possible. DFS will also contact law enforcement and request the police respond along with a DFS investigation worker.

Upon receiving a referral from the hospital for non-accidental trauma with life-threatening injury, DFS will make an initial contact with the hospital and family as soon as possible, generally within an hour or so. Even if the child is safe in the hospital, DFS is to evaluate the child's safety as if he or

she were at home in the care of the parents. Clear communication of the hospital's concerns will be important in helping DFS assess the situation. After the initial contact, the worker will consult with the DAG. Whether or not DFS will petition for custody of the child is dependent on many factors, including the availability of appropriate relatives, and is determined through the use of the Structured Decision Making Tool. There was a question posed as to whether there should be a recommendation that DFS take emergency custody in these cases prior to trying to identify relatives, holding a TDM, etc., but there was no resolution to this issue.

There was discussion about how cases are handled when the parents are suspected of causing the injuries but are cooperative and following medical advice. Generally, the hospital will just continue working with the parents and obtaining their consent. However, hospital staff expressed that they would prefer some oversight or an additional "set of eyes" on these cases as they progress. This might be a DFS worker, or preferably, a child advocate. Since a child's attorney is only appointed when there is Court action, the Workgroup would have to look into the feasibility of having a child's attorney appointed. As for DFS, they will not close a case until they are sure the child is safe, and are likely to keep an investigation or treatment case open during the entirety of a child's stay in the hospital even if they do not petition for custody.

This led to a question of whether parents who are suspected of causing the injuries should be allowed to make these decisions, even if they are following medical advice. This is an issue the Workgroup will need to address, while taking into consideration American Academy of Pediatrics standards, and which may require statutory change.

c. Communication/Points of Contact

Hospital staff agreed that they should contact the hospital's risk management department as soon as a child presents with life-threatening injuries that are suspicious for abuse.

During DFS' investigation, new or ongoing concerns of hospital staff should be relayed to the investigation worker, or, if unavailable, his or her supervisor, who will update the DAG with significant information. In turn, DFS' point of contact should be the hospital's social work department.

During the investigation of a case of suspected child abuse with life-threatening injury, if there is a perceived disconnect between hospital staff and DFS, counsel for the hospital and counsel for DFS should communicate with one another.

d. Communication of Recommendation to De-escalate

Once DFS has obtained legal custody of a child, and a recommendation to de-escalate care is being made by the hospital, it was agreed that a family meeting would be held, to include at least one treating physician from each discipline treating the child and other hospital representatives who contributed to the recommendation, the parents, the parents' attorneys, the DFS worker, the DAG for DFS, and the child's attorney. The hospital will initially communicate its recommendation to DFS, and DFS will be responsible for contacting the other parties and counsel to arrange the meeting. The purpose of this meeting is for all parties to receive the same information at the same time about the child's condition, prognosis, and the recommendation to de-escalate care. Hospital staff noted that a recommendation to de-escalate care will not be made unless it is a nearly unanimous decision among all doctors, disciplines, and consultants involved with the child.

IV. Next Meeting Date

The next meeting will be held on June 14, 2017, from 1:00-3:00 p.m. The meeting will be held at A.I. duPont Hospital for Children, with video conferencing to the Sussex County Family Courthouse as well as a telephone conference call line.

V. Public Comment

There were no members of the public present.

VI. Adjournment

The meeting was adjourned at 2:00 p.m.